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Toward an International Recovery Research Agenda: An Interview with David Best, PhD

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Introduction

As a new recovery advocacy movement rose in the United States in the late 1990s and began to spread around the world, there were calls for the development of a recovery research agenda that could add to the large body of existing studies on addiction-related pathologies and addiction treatment methods. One of the scientists outside the U.S. heeding that call was Dr. David Best. David was at times catalyst and always close observer of recovery advocacy efforts, first in the UK and then in Australia, and led a series of important recovery-focused research studies in both countries. It has been one of the great privileges of my professional career to have collaborated with David on some of these studies. In August 2012, I asked David to reflect on his career as a recovery researcher and to share his observations about the state of recovery advocacy in the UK and Australia. Please join us in this engaging conversation.

Discovery of Recovery Research

Bill White: David, could you describe your initial motivation for specializing in addiction research?

David Best: Well, I recently read some statistical evidence suggesting one in ten people in Scotland have an alcoholic family member. My mother's father was a street drinker who was consistently in trouble with the police. My mother was frequently called on Sundays to bail him out of custody suites and cellblocks. As I entered my adolescence, my father became an alcoholic and ended up having to give up his work because of alcohol-related peripheral neuropathy. So alcoholism was always a family issue for me, and I was always concerned about those larger issues of family well-being and alcoholism and the poor quality of treatment services that were available. I mean, you saw your GP, or if it was bad enough, you'd get sent to detox or an old psychiatric hospital. Those were pretty bleak options.

And entirely unrelated to that, I'd ended my undergraduate degree in psychology and philosophy and started work on my Ph.D. My primary interest at that point was about the effectiveness of communication and how people see things and convey meanings in what they see. Through that, I got approached by a wonderful eccentric academic at the University of Strathclyde, John Booth Davies, author of *The Myth of Addiction*. This was basically a book about the social construction of addiction. Davies was interested in how and why people attributed the addiction concept to themselves and how much of that was context-specific to deal with the structures of treatment and support that were available. Davies and I worked together on a Scottish Office-funded grant, which became the subject matter for my Ph.D. I focused on how people understand their own state in and out of treatment and how they describe their own addiction state. What we were interested in was five questions: 1) do you see yourself as an addict, 2) how do you understand yourself to have become addicted, 3) why do you want treatment (or not), and what do you think it can do for you, 4) why did you see yourself having a problem, and 5) what does addiction mean to you and what effect does it have on your life? We were very interested in the potential therapeutic benefits of trying to change the attributions people have about themselves and their problems.

I was then lucky enough to be offered a job at the National Addiction Center in the Institute of Psychiatry in London. This was a major research center for all of psychiatry, and I was in a really fortunate position. We had a significant research unit, but we also ran a wide range of clinical services from a large methadone maintenance program to a number of residential detoxification and rehabilitation services, plus a range of community support services. It was in the ten or so years I was there that I developed my focus on recovery. It seemed sometimes like I was a lone voice in the UK focused on recovery (which I wasn't), but most of the work of this period in the UK focused on very cold clinical measures of reductions in use or

injecting, offending, and risk-taking, but ignored such issues as well-being, purpose, meaning, or connectedness.

Our services didn't do well at all: it felt like our client group really didn't progress. Much of what I wrote at that time was critical of treatment. It eventually took me to the idea of medication-assisted recovery, but at that time, recovery was not the focus. At the Department of Psychiatry at the University of Birmingham, we did a large-scale survey and for the first time, really collected the evidence that what we had been calling treatment of drug users largely wasn't really treatment. It was prescribing and a very brief chat. There was very little in the way of therapy for clients—no real psychological interventions. I was becoming increasingly skeptical and disillusioned about how treatment was being offered and what treatment was being offered to people.

Bill White: David, was that the beginning of your interest in recovery-focused research?

David Best: Yes, absolutely. I was very skeptical of treatment and then, sparing all blushes at your end, I came across some of your work and it started me thinking, and I realized this wasn't the experience that everybody had. I guess I'd always known there were very different ways people managed addiction problems, but reading your work started my search to answer a very simple question: why is there so little science of success in our field? Why are we so insistent on being a science of pathology? From that point onwards, six or seven years ago now, this notion of recovery has been my central research concern. There was this review about mental health recovery in the *British Journal of Psychiatry* last year that included the acronym CHIME for connectedness, hope, identity, meaning, and empowerment. That really sums it up for me in terms of where I hope the pendulum swings.

Recovery Links to Treatment and Prevention

Bill White: You are one of the few researchers I know whose career has actually spanned prevention, treatment, and harm reduction and then ended up with this focus on recovery. Did these other areas inform your recovery research?

David Best: Oh, absolutely. I feel one of the completely unproductive and false polarizations is the often portrayed chasm between harm reduction and the recovery movement. You know, I'm still hugely enthusiastic about things like take-home naloxone programs to prevent overdose fatalities. It seems to me that one of the things that recovery literature and evidence has shown us is a developmental recovery perspective. It's crucial that we offer a range of services and supports for different stages of change. Harm reduction interventions like needle exchanges and naloxone take-home programs are absolutely essential to the idea of helping people through the initial chaotic stages of addiction and empowering people to take control of their own drug use careers and their own recovery processes. As a researcher, I have been able to study and see the value of a whole range of different treatment, prevention, harm reduction, and recovery strategies. What links all of these is the necessity of interpersonal transmission of respect and hope.

Bill White: Has your earlier background in prevention helped you see connections between this new recovery focus and primary prevention?

David Best: Absolutely. It seems to me that the crucial overlaps between recovery and prevention are the ideas of empowerment and social support. These underpinning social influences are critical processes if you want to understand causes and shape effective prevention strategies, early interventions, formal treatment interventions, and processes of long-term recovery management.

Bill White: What do you think about mobilizing individuals and families in recovery as a force for long-term prevention within local communities?

David Best: One of the fascinating social policy and academic challenges is to generate attractive icons of recovery in the community—true recovery champions. I see these champions as beacons of recovery—the walking, living, breathing success icons. In recovery language, the primary purpose of this group is to engage and attract those in active addiction and to engage and attract those who are caught in treatment without a sense of hope or direction. Recovery champions can convey the possibility that things can be different and offer living proof of that difference in their own lives. They can also offer guidance and direction for people's recovery journeys, but I think the point you make is an absolutely crucial one, that the viability and the visibility of those individuals would have an effect beyond people who're initiating their own recovery. They would become a huge community prevention asset. I think one group that would be interesting to work with would be the aboriginal communities, where there's anecdotal evidence of precisely that effect—individuals who transform themselves and then help transform their communities.

Early Treatment Outcome Studies

Bill White: I'd like to take you to review some of the research studies that you've been involved in. A lot of your early work was in conducting treatment outcome studies. What were some of the most important lessons you drew from those studies?

David Best: The vast majority of addiction treatment outcome studies show impressive effects. Treatment can make a massive difference in peoples' lives across a whole spectrum of measurable outcomes and across many modalities, including detox, rehab, methadone maintenance, and methadone reduction programs. My concern is that we have evaluated such effects on primarily a short-term basis. We don't focus

enough on what comes after the acute treatments—in short, we study immediate effects of treatment but not the more prolonged course of addiction or the prolonged course of recovery. In the UK and in the States, we tend to view what happens in this longer term perspective in terms of the consequence of the medications or talking therapies we provide and not broader influences on addiction and recovery. We also still cling to a model that is about pathology management, which has two implications, the first being that we don't focus enough on strengths and the second that we reinforce a model that sees addiction (and recovery) as incorporated rather than as being socially mediated and managed.

I think we miss two things that matter. One is the basic human contact and relationships that surround addiction treatment therapies, and the second is the effects treatment can exert on people's social networks and daily activities. It seems to me that the real outcome measures of value are the social networks people are embedded in, the degree of commitment to these social networks, and the things that fill their daily lives.

The interesting issue for me is much less about what particular therapies and modalities we offer and more about whether we can inspire belief that recovery is possible, establish a partnership between the client and the worker to facilitate that change, mobilize recovery supports within the client's natural environment, and link the client to those community resources. We also need to locate recovery within a developmental perspective that recognizes the lengthy (and non-linear) journey that most people experience in recovery. This means there are plenty of opportunities for a diverse array of interventions and also that people will evolve in their needs and their resources as the recovery journey progresses.

Studies of AA and NA in the UK

Bill White: Your reference to community resources reminds me of the studies you've done on AA and NA and professional

attitudes towards those organizations in the UK. Could you highlight some of your findings in this area?

David Best: Yes. One of the fascinating things around professional services in the UK has been their increasing focus on technical skills and technical delivery. The requirement that staff have professional qualifications has acted as a barrier to former users becoming involved as workers in our field. As a result, there is a mistrust of non-professional community interventions and particularly 12-Step mutual aid groups in the UK and even more so in Australia. There are a whole series of myths that prevent effective cooperation with these groups. There is a pervasive view that cooperation with recovery mutual aid groups, particularly AA and NA, are incompatible with a secular evidence-based model of treatment.

One of things that's always really interested me is how little drug and alcohol workers in the UK, and I suspect the same is true here in Australia, actually know about the evidence base for linkage of clients to 12-Step groups. Most workers in UK Services have never been to a 12-Step meeting, and the idea that knowledge of such recovery support resources is a key dimension of one's professional development is relatively new. In January, we start the first post-graduate diploma course here in recovery. One of the requirements for the students, almost all workers in the field, will be to attend at least one open mutual aid group meeting and write a reflection on that experience. I think it will be an enormous challenge for us to actually get people to do that.

We did a linkage study that was published last year showing, as has been found in the States, people linked from detox services to mutual aid groups have better recovery outcomes than those not linked to such groups. Well, this isn't really surprising, but it's so inconsistent with our prevailing treatment philosophies. It seems to me that one of the crucial parts of the recovery movement is to focus on cultural change in the addiction treatment workforce, and I think this is probably more of an issue in the

UK and Australia than it would be in the States. We have to first overcome the suspicions around mutual aid groups and other community-based recovery support resources. Equally important, we must address issues around staff burnout, which I suggest is related to repeated exposure to client relapses without parallel exposure to clients in long-term recovery. I'm interested to see if increased recovery orientation in treatment helps workers as well as clients.

One of my most disappointing experiences as a researcher was some work I did in North Wales a couple of years ago. I asked workers in the field to estimate how many people with a lifetime drug and alcohol dependence diagnosis would ever achieve long-term stable recovery. Now a recent review from the Center for Substance Abuse Treatment reported an estimated 58% recovery rate. Workers in our field in North Wales estimated that only seven percent, on average, would eventually recover. That kind of therapeutic pessimism is a major barrier to the effective implementation of a recovery model and why such a model is so desperately needed. Too many workers sit in offices and only see people who're either stuck in active addiction or are in a revolving door of treatment services. Rarely do they see the people living full, productive, meaningful lives in long-term recovery. Workers as well as clients need exposure to these recovery role models.

Recovery Stories

Bill White: I'm very interested in the bridge between your work evaluating AA and NA and your growing interest in the role of recovery capital in long-term addiction recovery. Could you talk about that work?

David Best: It's just fascinating to me. There's an interesting thing about doing recovery studies, and I've collected just over 1,000 recovery stories in total now. And one of the things I've become really interested in is the question, "What are the characteristics of people who achieve recovery from addiction?" In a paper you did some years ago with William Cloud, you argued that the

prospects of long-term recovery were more determined by a person's recovery capital [level of internal and external assets] than by the severity or chronicity of their addiction. I've become very, very interested in that issue, particularly the question of what constitutes social capital. What constitutes that connectedness and embeddedness and belonging that helps people make those lasting changes? And, because our treatment services in the UK and Australia are so typically professionally driven, I became interested in the links between treatment and the recovery community and how the degree of recovery friendliness of a society affects recovery outcomes.

One of the challenges that I still get and I suspect you do also is that recovery is just wishful thinking, that there's not really much of an evidence base for it. It seems to me that the potentially predictive power of the growth of recovery capital is one of those areas where, without having to have a single consensual definition of recovery, we can start to provide a genuine, quantifiable scientific method of measurement of change. I'm really quite interested in how recovery capital changes among people who are and who are not engaged in different kinds of recovery groups and other recovery support activities.

Community Recovery Capital

Bill White: Your work in evaluating recovery capital led you back into something you briefly referenced earlier, which is this notion that recovery can become socially contagious in the life of a community.

David Best: I have to say that this has been the most exciting experience of this work for me. It's what has made this such an inspiring thing to be involved in—these people who provide you with such astonishing inspiration and hope. As soon as you said that, 10 or 15 people's faces popped into my head almost as if in a slideshow of people who have just astonished me, not only with their own stories, but their capacity to generate change in other people around them.

I think one of the most astonishing things about recovery is the capacity for people not only to enable their own recovery journeys but to give back and make it possible for other people to change their lives. There's something magical about the coming together of a small group of those attractive, energetic, dynamic, and vibrant recovery champions. They create such an incredibly powerful and positive energy for change at three levels—firstly, in their own communities, secondly among skeptical and cynical professional attitudes, and thirdly at the strategic and policymaking commissioning level. Those individuals really are the recovery movement, and I regard it as a genuine privilege on my part to be able to document the experiences of some of those individuals.

One of the really interesting questions for me at the moment is how we identify and support and enable people to become these recovery icons and recovery champions without threatening themselves, without putting at risk their own recovery. I've read recently quite a lot of literature around the Social Identity Model of Identity Change, and there are some really interesting things that happen. We know from the literature around HIV and acquired brain injury that people who choose to disclose their status and who, as a consequence of that disclosure, are able to access supportive groups in their local community report higher self-esteem and better quality of life. It fits entirely with the notion of connectedness to and belonging within social networks and social groups, but extends that idea to incorporate the dynamic influence that a sense of belonging can have on personal wellbeing and perceived identity—key aspects of the recovery journey. And we know such groups can support people on their recovery journeys in terms of a safety net, social support, quality of life, access to opportunity, and access to social resources. I have the most incredible respect for the 12-Step movement and how people are reconciling their anonymity within the mutual aid movement while pursuing concurrent opportunities to become active, physical,

vibrant, and contagious transmitters of recovery in their local communities.

Recovery Advocacy in the UK

Bill White: You've had an opportunity to be both a very close observer and contributor to the rise of a recovery advocacy movement in the UK. How would you describe the rise of that movement?

David Best: I think one of the fascinating and unique challenges of describing this is that it's primarily local, and it's unpredictable. I'm recalling the work we did in a small mining town in Yorkshire where we tried to generate a small group of people to be champions for recovery. It was something that was astonishingly substantial that started with a very small group of people who came together to share their thoughts and ideas. They were from very diverse recovery backgrounds and belief systems, but they managed to generate a shared set of visions and ideas and since then, they've done the most incredible things, including recovery walks, recovery activities and events, art days, and family days. It's been such a positive inspiration to observe what has unfolded there. But it is dangerous to try and generalize or to create rules and processes about how this happens. It's very idiosyncratic, or perhaps I'm just a bad researcher who can't discover the underlying principles, but one of the fundamental components of such movements is that they have to be locally driven and locally led if they are going to work.

I think one of the beautiful things of the emergence of the advocacy movement in the UK has been its diversity. In spite of a couple of attempts to try and homogenize and manage the process, it remains wonderfully idiosyncratic and diverse, and incredibly pluralistic in terms of the range of opinions and views. I was first frustrated that there did not seem to be any central movement emerging, but in retrospect, that's a genuine strength of what's happened in the UK. There aren't any significant national recovery leaders in the UK, and in some ways, maybe that's exactly as it ought to be.

There are important teachers and documenters, and there are some key policymakers, but recovery doesn't have a single leader in the UK, and I suspect that's probably a good thing. The attempts at creating unifying umbrella organizations have not been convincing to date, and I suspect that this is about an intrinsic mistrust of professionalization. The movement remains a series of linked networks of powerful, charismatic individuals who come together to do some things and don't come together to do others. It's much more a series of little cells and units and groups, and that's a good thing. They share some views and don't share others.

Recovery as a New Organizing Paradigm

Bill White: In spite of that lack of leadership, you have witnessed the elevation of recovery as a new organizing concept at the policy level. What influence do you see this new focus exerting on addiction treatment in the UK?

David Best: It's been such a fascinating process, and it's a process that I've seen also happening and emerging in Victoria here in Australia. The embrace of the recovery concept has happened much, much faster by policymakers than by professionals involved in the treatment field. Many of the latter have been resistant to recovery ideas for a whole range of reasons. It's been very interesting to watch this happen in Victoria where the reform road map for alcohol and drug services has recovery in its title. That sent shockwaves through the field and has led to some unease among workers who see this concept as challenging the dominant harm reduction philosophy and leading towards a payment by results approach.

I think the big advantage of recovery as an organizing concept is the rallying cry for hope that's allowing recovering people who are energetic, driven, optimistic, and aspirationally based to have a focal point for their activities. It wasn't particularly planned that way, but it chimed with a movement for localism, for community ownership, and for a

public health model based on community assets. The rapid emergence of a recovery model at the policy level has forced some stumbling as we try and work through what that means. There is a recognition that this isn't more of the same or going back to something we used to do but is instead a fundamental and radical reorientation of how we view the resolution process from addiction. I think the notion of community empowerment is part of this, that many of the solutions for long-term changes at the primary prevention level as well as at the level of long-term personal recovery are community-owned, not professionally owned and driven.

The Recovery Academy

Bill White: You contributed to the growing science of recovery in the UK through your own research and through your leadership in the Recovery Academy. Could you discuss the work of the Recovery Academy?

David Best: Yes. I'm pleased to say we have a Recovery Academy Australia now gradually coming into fruition. It was officially launched on September 21, 2012, in spite of meetings having taken place since September 2011 and the walk happening in April 2012. The purpose of the Recovery Academy was to collect existing knowledge about recovery and build a larger base of scientific studies about recovery. There were so many exciting, innovative activities going on around recovery in the UK that weren't being measured or evaluated. The thing I wanted to do was to bring together researchers and academics who are interested in recovery questions with local recovery groups. It was an effort to develop a shared communication and a shared evidence base around what works in the arena of recovery support. And that's also what we are trying to do with Recovery Academy Australia.

Recovery-focused research is growing. There are lots of studies that have been done and more emerging in tandem with the mental health recovery movement and the desistance movement in

criminology. One of the things that I'd really like to see is a movement towards preparing blocks of Ph.D. students to become the evaluators, auditors, and researchers who will help answer questions about what works in recovery processes for service organizations and for whole communities. We've described the emergence of this recovery orientation of services and agencies and workers. It is time to bring that to an accessible set of measurable tools that can aid people who're setting up recovery communities.

I think one of the really exciting things about recovery is it's a different paradigm. We can and we will utilize the traditional methods and the trials and outcome studies if we need to, but I think recovery science will be far more diverse and pluralistic in its research methods and its use of social media. I think that we can try and develop a core set of beliefs and values and understandings about the why and the how of recovery research. One of the challenges you and I face is how to articulate and support the development of a recovery research language that's credible and meaningful to policymakers and service providers while also being consistent with the values of the people that we're working with.

Recovery Research and Advocacy in Australia

Bill White: I'm very interested in your transition from the UK to your work in Australia and the similarities and differences you've found in terms of recovery research and the comparable status of recovery advocacy.

David Best: I think one of the things that Australia's quite proud of is a very effective and successful harm reduction movement. There's been considerable commitment and resources given towards needle and syringe programs as well as methadone maintenance programs. Achieving that has been a significant struggle, but it is now well-established and a dominant model. That's why a number of people are very, very

nervous about the talk of recovery. Many people thought this was merely a call to return to an abstinence-dominated 12-Step model. I've tried to be as conciliatory as possible because I really don't see this in either/or terms. It seems to me that in the Australian context, the approach one has to take is in expanding options and opportunities. It's been very interesting because there are a number of very viable recovery agencies and champions. We had the first Recovery Walk in Australia. I've championed these events to celebrate the astonishing achievement of recovery, to socially link people in recovery into networks of mutual support, to help people engaged in long-term treatment engage in a more encompassing recovery process, to engage family members, partners, and children of people in recovery, and to challenge social stigma and discrimination. So, we had our first ever Recovery Walk in Australia with more than 400 people taking part.

One of the things that's been of concern for me has been the number of professionals who are in recovery but who will not talk about this because they fear in a harm reduction-dominated system, this could have significant adverse effects on their careers. There still remains a significant barrier to people becoming visible in their recovery because of fears of adverse reactions from a relatively small but vocal group of militant harm reductionists. That's now beginning to change. I did a presentation to the Chapter of Addiction Medicine in Victoria earlier this week on recovery, and I'd expected a fairly hostile time of it as I probably would have had a year or so ago. I really need to say that the message is getting through, that the Recovery Advocacy Movement is making a positive contribution, but it's a gradual process. In the book that you edited with John Kelly, several authors noted that this recovery transformation process at a systems level takes five to 10 years. In Victoria, we are at the start of this journey and there are other parts of Australia, including New South Wales, where the journey simply hasn't started yet and where there's considerable resistance to it.

Bill White: Australia would seem to be the ideal setting to conceptually integrate recovery and harm reduction perspectives and methods. Do you have hopes that this will occur?

David Best: Absolutely. I think there's a real opportunity for it here. It's starting with the idea of medication-assisted recovery. How can we bring recovery champions and recovery-focused social connections to long-term prescribing clinics? I think one of the other things that's potentially quite useful here is that the mental health recovery movement has been well-established and is well-supported in Australia. Because many of the large new health providers cover both mental health and alcohol and other drug problems, I think some cross-contamination and cross-fertilization is going to be possible. Australians are generally such an upbeat, positive, and enthusiastic group of people. It's such a young and vibrant country with incredible resources. I realize I'm gushing a bit here, but it's an amazing place, which affords the opportunity for innovation and trial. There are just huge opportunities here for trying to do things in a different way that would be meaningful for individuals, families, and communities.

I have this vision of linked networks of community connectors consisting of three levels of people in recovery and members of their families; workers in specialist agencies; and visionary community leaders, each engaged in growing and binding networks of personal and social capital that are linked through activities and a common vision. Their joint activities and their recovery advocacy become beacons of hope and hubs of change in deprived communities.

Personal Reflections

Bill White: If you look at your work to date, what do you feel best about?

David Best: I would like to think I've helped shift the recovery movement forward in the UK and in Australia. I've provided evidence that challenges the notion that people don't

recover from addiction, and I've documented how recovery varies from person to person. It's idiosyncratic, but it happens, and we can measure the changes involved. I think that getting that message through to policymakers, practitioners, and the public is important, but even more important to me is helping increase the visibility of the advocacy movement and the sense of hope and pride that it is generating among people in recovery. Recovering people are beginning to fully recognize the value they can be to each other, their families, and their communities. I'd like to think I've helped stir that recognition.

I'm particularly pleased with what has unfolded in Yorkshire in the UK. We started this fledgling local recovery movement in Barnsley last year with a group of maybe 20 to 30 interested people. This work has led to an incredibly vibrant and diverse set of activities and events that have inspired all kinds of community groups and individuals and have changed the beliefs of people about what they can do and what their peers can achieve. I am currently taking this work forward in York, where there is enormous potential to generate networks and communities of recovery supported and inspired by a commissioning team committed to recovery and a city that recognizes the enormous potential and resource of people in recovery. Within only a year, we've received a commitment of support from the city, we've got an expanding and growing army of champions, and we're seeing this blossoming of hope. Any role I could have played in helping spread this contagion of hope is a far better achievement for me than any of the research studies I've written or published.

Bill White: David, thank you for taking this time to share your experience and perspective with us, and thank you for all you have done on behalf of people seeking recovery.